Revised 2/09

Virginia Department of Rehabilitative Services
Personal Assistance Services
UAI ADDENDUM

Authorization Date: _____

Assessment Date _____

Initial Assessment ☐

Reassessment ☐

VR transfer to State PAS ☐

Applicant/Consumer Name, Address, Telephone, Email	DRS PAS Staff Person	Assessor Name, Telephone

Background: (If this is a re-assessment, please note any changes in consumer living, personal assistance, financial, or family circumstances, which impact the need for DRS PAS.)

List names, ages, and relationships of all persons living in the home.

Name	Age	Relationship

Eligibility for Medicaid Waiver Personal Assistance Services

What is the date of the most recent screening for Medicaid Waiver Personal Assistance Services with the Department of Medical Assistance Services?_____

If ruled ineligible because of income, please give date and results of last Medicaid application.

_____

Enclose a copy of the eligibility letter that lists reasons for denial

If Yes, which Waiver? _____ Date Started _____How many hours? _____/week

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Disability and Functional Limitations

Please mark an "X" in the appropriate box for primary and secondary reason for functional limitations which lead to the need for personal assistance:

Disability or Condition	Primary	Secondary	Disability or Condition	Primary	Secondary
AIDS/HIV			Lupus		
ALS (Lou Gherig Disease)			Mental Illness		
Arthritis			Multiple Sclerosis		
Ataxia			Muscular Dystrophy		
Blindness/Visual Impairment			Orthopedic Impairment		
Burn Injuries			Post-Polio Syndrome		
Cancer			Seizure Disorder		
Cerebral Palsy			Spina Bifida		
Deafness/Hard of Hearing			Spinal Cord Injury		
Diabetes			Stroke		
Heart and/or Lung Disease			Traumatic Brain Injury		
Hypertension			Other		
Kidney Disease			Other		

Briefly describe functional limitations resulting from disabilities or related conditions.

Functional Status

Please mark with a **"√"** if individual requires assistance to perform the task

# daily	Transferring	Comments
	Unassisted	
	Supervision/positioning for safety	
	Mechanical assistance	
	Fully assisted with no mechanical device **time per transfer:	
	Other – please explain	

√ - if required	Meal Assistance	Breakfast	Lunch	Dinner	Snack
	Feeding by hand				
	Cut food and set up				
	Supervision				
	Unassisted				
	Comments				

√ - if required	Toileting (exclude inserting catheters or carrying out bowel programs)	Comments
	Preparation and clean-up time: How much total time daily?	

✓ If applies	Support Network	Comments
	Friends/family will be available in case of emergency	
	Has emergency evacuation plan	
	Other, please explain	

√ if applies	Short and Long Range Planning	Comments
	Independently makes transportation arrangements	
	Independently makes appointments to consult professionals as needed	
	Independently schedules classes and social activities	

√ if applies	Management of Personal Assistance Services	Comments
	Has recruited, hired, and managed personal assistants	
	Communicates an understanding of managing personal assistants	
	Has a realistic plan for hiring personal assistants	
	Has a realistic emergency back-up plan	
	Has successfully completed PAS Consumer Orientation Training	

Recommendations

- Continue services at current level ☐
- Review assessment for adjustment of hours ☐
- Re-evaluate income and resources ☐
- Terminate/deny eligibility based on: ☐
- Needs currently being met by other programs ☐
- Unable to manage independently ☐
- Does not require assistance with ADLs ☐

Basis for recommendations

Work/Training PAS Needs

(***Please check only one in each category***)

√ - if required	School/Training	# of hours per day	# days per week
	Transportation to and/or from school or training by a personal assistant.		
	Personal Assistance at school or training site – Describe needs:		
	Hands-on Assistance with school work at home or in the library– Describe needs:		
	Has the school/training site official been asked to provide reasonable accommodations? If yes, please describe results:		

√ - if required	Work activities	# of hours per day	# days per week
	Transportation to and/or from work by a personal assistant.		
	Hands on assistance at work – Describe needs:		
	Has the employer been contacted to ask about reasonable accommodations? If yes, please describe results:		

PAS SERVICE IMPACT

LIVING ARRANGEMENTS **(Please check one)**

If provided with personal assistance this person will:

	Move from a nursing home to a less restrictive community living arrangement.
	Cancel current active plans for entering a nursing home. (This must be documented.)
	Be able to move from a housing arrangement which the individual experiences as inadequate to a less restrictive and more desirable living environment.
	Be able to achieve greater independence in the current environment in which help has been unpredictable or inadequate.
	Not experience any change in living arrangements.
	Currently is receiving PAS, no change indicated.

EMPLOYMENT STATUS

If provided with personal assistance this person will be:

	Be able to continue employment which was obtained with Vocational Rehabilitation assistance and VR PAS Support and would cease without continuation of PAS.
	Be able to maintain employment that is currently in serious jeopardy due to a lack of needed personal assistance.
	Be able to increase work hours, or move from a sheltered workshop or supported employment to competitive employment.
	There will be no change in employment status.
	Is currently receiving PAS, no change is indicated.

TRAINING/EDUCATIONAL STATUS

If provided with personal assistance this person will be

	Be able to enroll in a school or training program that is currently not an option due to the lack of personal assistance.
	Be able to remain in a school or a training program which is currently in jeopardy due to a lack of personal assistance.
	No change as a result of PAS.

PHYSICAL HEALTH **

	This individual is experiencing acute or chronic health problems directly related to the lack of any hands on assistance with activities of daily living, i.e. bathing, toileting, dressing, transferring, and eating.
	This individual is *not stable* and has age related, injury related, or disease related conditions which require more personal assistance than currently received.
	This individual has no chronic health conditions but is at risk of injury from falls due to a history of falling with injuries.
	This individual has chronic health conditions such as diabetes, heart disease, respiratory disease, but is currently stable.
	There will be no effect on overall health.

CURRENT VOLUNTEER/FAMILY PROVIDER OF SERVICES

	This individual is in need of personal assistance and currently receives *no assistance*, either paid or unpaid.
	This individual is in need of personal assistance, and currently receives volunteer/family help. The volunteer/family member is unable to work because of the need to provide the level of ongoing personal assistance needed. This has resulted in significant financial hardship. The volunteer/family member will work outside of the home if paid personal assistance is provided.
	This individual receives volunteer/family help that is of limited or declining benefit due to the advanced age or poor health of the caregiver. Personal Assistance is frequently not happening due to the problems of the caregiver.
	Individual is really in need of greater personal assistance and currently receives only volunteer or family assistance.
	Individual receives adequate volunteer /family personal assistance but desires a more independent, consumer-directed alternative.

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COMPARABLE BENEFITS

	This person has significant physical limitations, has demonstrated the ability to participate in a consumer-directed program, and has documented proof of screening for Medicaid Waivers, and any other comparable programs within the last three months. This person was subsequently found ineligible after supplying all required financial information. This person has applied to the Department of Social Services, Home Based Services Program and Area Agency on Aging programs. This person is not currently receiving any of these services. This person will notify DRS PAS when comparable services are offered.
	This person meets nursing home admission requirements and qualified for Medicaid Waiver Services. However this person has been unable to secure a licensed nurse provider and an agency provider for in-home assistance because of the isolated location of the home. (This must be fully documented.)

FAMILY STATUS

	This individual is **living alone** and has no extended family or friends providing personal assistance.
	This individual's family caretaker/volunteer is at a crisis stage and showing documented signs of either "burnout", emotional overload, physical exhaustion, or spiraling debt due to the strain of providing personal assistance.
	The family situation is stable, but is expected to change significantly in less than one year due to health problems of the primary family caretaker/volunteer, planned relocation of the consumer, or a progressive condition of the individual which will require additional personal assistance very soon.
	The family situation is stable and not expected to change in the near future. However, this person desires a non-family provider.

ABILITY TO MANAGE SERVICES

This person has:

	Demonstrated the ability to supervise a personal assistant with minimal support and guidance.
	Demonstrated a possible ability to supervise a personal assistant but will require extensive training and support.
	Does not demonstrate an understanding of their own personal care needs and has not demonstrated the ability to manage a consumer directed personal assistance program.

Final Summary of Addendum

Completed by _____**Date:** _____